

Minutes

Increasing Access to Services Provided through Indian Health Services Subgroup

Conference Call- 9/18/15

11:00 am to 12:00 pm

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Jason Dilges, Tony Venhuizen, Brenda Tidball-Zeltinger, Ron Cornelius, Richard Huff, Mike Deidrich, Deb Fischer-Clemens, Senator Troy Heinert, Monica Huber, Tim Rave, Scott Duke, Gil Johnson.

Kim outlined the purpose of the subgroup. The workgroup is charged with identifying specific strategies that increase access to services provided through Indian Health Services.

Ron Cornelius outlined the process for how referred care with I.H.S. works. Estimated range of funding for referred care \$9-\$10 million and that is for services in North Dakota, South Dakota, Nebraska, and Iowa. I.H.S. Majority of care is priority 1 which is “life or limb” situations. Priority 2-4 very limited based on funding. The need for care exceeds the funding available. Individuals are referred and then a determination is made if the care is eligible for payment. If approved, a purchase order is issued to provide funding for the referred care. Deb Fischer-Clemens asked if there were opportunities to improve or streamline the process. Ron outlined the process underway through a workgroup focusing on this piece.

Kim asked if I.H.S. could provide data on the type of care that is referred. Ron indicated they had data on the type of referred care and could provide in one week. Data is somewhat limited in terms of what is readily available but he will provide what they have and continue to talk with his team about other ways to get more refined information. Indian Health Services doesn't have specific data on whether care was received due to limitations in case management system. Kim also asked if there was information regarding the determination of what is an eligible service.

Kim outlined that CMS provided some feedback which centered on wanting more information and detail regarding increasing capacity through I.H.S. for clinic and physician based services, telehealth, and generally increasing access within I.H.S.

Deb Fischer-Clemens asked if there was a focus on particular types of care – i.e. primary care, specialty care, etc. Kim explained that at this point it's a broader construct but an example might be dialysis. CMS wasn't specific but CMS will find it easier when care is provided through I.H.S. Deb outlined examples of situations where telehealth that are achievable. The data from I.H.S. will help inform future strategies. Monica outlined that these services are being provided today but primary and urgent care is an area of need to explore.

Ron shared that several facilities have expanded hours similar to private models. Wagner I.H.S. has expanded coverage through walk in and appointments. The referred care data will inform where there are opportunities. Ron shared that reimbursement for telehealth is key in supporting the service given CMS low reimbursement rate. Kim asked Ron what I.H.S. would provide if the capacity were there through I.H.S. in terms of additional providers. Ron shared that there are capacity issues today with up to 20% vacancy rates. Lack of equipment such as MRIs also poses barriers.

Deb Fisher-Clemens asked about strategies or considerations by I.H.S. relative to care management, medical home, etc. Ron indicated they are looking at ways to expand case management and must consider those within the construct of resources.

Mike Diedrich outlined that Regional Health provides contracted services in Pine Ridge. One barrier is the degree of need exceeds I.H.S. contract resources. Approaches such as the embedded physician approach are one strategy in particular that can work with newly recruited physicians. Kim asked Mike if they had enough information to outline what capacity or needs could be addressed if those other issues are addressed. Mike asked about getting some data on population health in those areas to get a better indication of true need.

Monica shared that if funds were available they could work to expand capacity. Kim asked if Sanford could share ideas around types of clinics they could support or help with and offer. Once data is provided by Ron with referral needs that will help Sanford develop that information.

Senator Heinert asked if there is data available to inform the emergent/referred care items so we can better understand what kind of referrals result from that. Ron indicated they don't have that information today but are working to determine how they could get to that level of detail.

Kim asked the systems what timeframes would be needed to develop some concepts. The group suggested two weeks from the receipt of the various data sets on 9/25/15.

Next Steps/ Action Items:

1. Ron will work on data to outline the referred care data and get that to Lynne, Kim, and Brenda. Ron will submit by noon on 9/25/15. Ron and Mike will coordinate discussions to better understand I.H.S. population needs to assist in development of Regional Health's proposal.
2. Kim will send out the data files previously shared that outlined the Medicaid referred care by location and type of service.

3. Sanford, Regional, and Avera to provide information on how to approach these strategies. Avera will take lead on providing a template draft and that can then be used across systems for consistency. Deb will submit by noon on 9/25/15.

Next Meeting:

The large workgroup meets October 7. This subgroup will meet from 3-5pm on that same day. Sub-group members not a part of the large workgroup are welcome to attend the larger meeting to observe.